STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	f '		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	
		155365	B. WIN	G		07/06/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					EAST ST		
WABASE	I SKILLED CARE C	ENTER		WABAS	SH, IN 46992		
(X4) ID		FATEMENT OF DEFICIENCIES	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K0000	REGULATORT OR	LSC IDENTIFTING INFORMATION)		TAG			DATE
110000							
	A Post Survey D	Revisit (PSR) to the	K00	000	 Wabash Skilled Care CenterID)	
	-	e Recertification			NO. 155365Visit Completion		
	•				Date: 7/6/2012ISDH Plan of		
	and State Licen				CorrectionJuly 26,	ıtion	
		05/09/12 and a			2012Preparation and/or execution of this plan of correction in	iuUII	
	Quality Assurar				general, or this corrective action	on	
	Survey were co	•			in particular, does not constitu		
	Indiana State D	•			an admission or agreement by this facility of the facts alleged		
		dance with 42 CFR			conclusions set forth in this	OI	
	483.70(a).				statement of deficiencies. The		
					plan of correction and specific		
	Survey Date: 0	7/06/12			corrective actions are prepare		
					and/or executed in compliance with state and federal laws.Th		
	Facility Number				plan of correction constitutes of		
	Provider Numb				credible allegation of complian	nce	
	AIM Number: N	N/A			with all regulatory requirement		
					Our date of compliance is Aug 5, 2012.	just	
	Surveyor: Amy	Kelley, Life Safety			3, 2012.		
	Code Specialist						
	At this PSR surv	vey, Wabash Skilled					
	Care Center wa	s found not in					
	compliance wit	h Requirements for					
	Participation in						
	Medicare/Medi	caid, 42 CFR					
	Subpart 483.70						
	-	he 2000 edition of					
	the National Fir	e Protection					
		FPA) 101, Life Safety					
		apter 19, Existing					
		cupancies and 410					
	IAC 16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(X6) DATE

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155365	LDING	NSTRUCTION 01	(X3) DATE COMPI 07/06	ETED
NAME OF PROVIDER OR SUPPLIER WABASH SKILLED CARE CENTER			STREET A	ADDRESS, CITY, STATE, ZIP CODE AST ST 3H, IN 46992	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	floor of a four a basement wa of Type I (443) fully sprinklere includes the er to the lack of the between the Sk and the remain occupancy. The alarm system with detection in the areas open to the resident room detection at the has a capacity census of 17 are survey. The facility was compliance with regard to smoke coverage and so Only one area whave customare sprinklered, the west stairwell esprinklered. A facility services	wo hour separation cilled Care Center ing third floor e facility has a fire with smoke e corridors and the corridors. The do not have smoke is time. The facility of 25 and had a the time of this is found not in h state law in the detector prinkler coverage. Where residents y access was not e bottom of the				

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Event ID: QDJB22

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155365	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPL 07/06/	ETED
	PROVIDER OR SUPPLIER H SKILLED CARE CENTER	710 N E	ADDRESS, CITY, STATE, ZIP (EAST ST SH, IN 46992	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	ATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIJII	DINC	01	COMPL	ETED
	155365		A. BUII B. WIN			07/06/	2012
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					EAST ST		
WABASH SKILLED CARE CENTER					SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0056	NFPA 101	ODE CTANDADD					
SS=E		ODE STANDARD omatic sprinkler system, it is					
		dance with NFPA 13,					
		Installation of Sprinkler					
		ride complete coverage for all					
	portions of the bi	uilding. The system is					
		ned in accordance with NFPA					
		the Inspection, Testing, and					
		Water-Based Fire Protection lly supervised. There is a					
	•	e water supply for the					
	•	ed sprinkler systems are					
		ater flow and tamper					
	switches, which	are electrically connected to					
	the building fire a	alarm system. 19.3.5					
	Based on obser	vation and	K00	56	Wabash Skilled Care CenterID)	08/05/2012
	interview, the f	acility failed to			NO. 155365Visit Completion Date: 7/6/2012ISDH Plan of		
	ensure complet	te automatic			CorrectionJuly 26,		
	sprinkler syster	m was provided for			2012Preparation and/or execu	tion	
	1 of 3 stairwell	s in accordance			of this plan of correction in		
	with NFPA 13, 9	Standard for the			general, or this corrective action in particular, does not constitute.		
	Installation of S	Sprinkler Systems,			an admission or agreement by		
		plete coverage for			this facility of the facts alleged		
		the building. NFPA			conclusions set forth in this		
	13, Section 5–1	_			statement of deficiencies. The		
	*	e stair shafts with			plan of correction and specific corrective actions are prepared	d	
		e stairs, sprinklers			and/or executed in compliance		
		ed at the top of the			with state and federal laws.Thi		
		•			plan of correction constitutes of		
		r the first landing			credible allegation of complian		
		om of the shaft.			with all regulatory requirement Our date of compliance is Aug		
	Exception: Spri				5, 2012.K056 It is the intent of		
	installed benea				this facility to ensure that a		
		e the area beneath			sprinkler system is provided in	the	
	is used for stor	age. This deficient			stairwell in accordance with		
	practice could	affect any resident			NFPA 13. What corrective acti		
					will be accomplished for those		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	01	COMPLE	
155365		B. WIN	IG		07/06/2	2012	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
111111111111111111111111111111111111111	NO VIDEN ON BOTTELLS				EAST ST		
WABASH SKILLED CARE CENTER				WABAS	SH, IN 46992		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	evacuated thro	ugh west stairwell.			residents found to have been		
					affected by the deficient praction. The west stairwell, lowest leve		
	Findings includ	le:			will be sprinkled. A proposal fo		
					the work has been received ar		
	Based on an ob	servation with			approved. Staff in Wabash Ski	lled	
		echnician # 8 on			Care Center have been notifie		
		25 p.m., the west			the course of action in the eve	nt	
		l sprinkler coverage			of a fire. How will the facility identify other residents having	the	
		of the stairwell.			potiential to be affected by the		
					same deficeient practice and		
	This was ackno	<i>,</i>			what corrective action will be		
		echnician # 8 at the			taken?All residents have the		
	time of observa	ation.			potential to be affected by the alleged deficiency. The west		
					stairwell, lowest level, will be		
	3.1-19(b)				sprinkled. A proposal for the w	ork	
	3.1-19(ff)				has been received and approv		
					Staff in Wabash Skilled Care		
					Center have been notified of the	-	
					course of action in the event of fire. What measures will be pu		
					into place or what systemic	١	
					changes will be made to ensur	e	
					that the deficient practice does	;	
					not occur?The automatic		
					sprinkler system will be tested		
					accordance with NFPA 25.How will the corrective action be	v	
					monitored to ensure the deficie	ent	
					practice does not recur?The		
					automatic sprinkler system will		
					tested in accordance with NFP	Ά	
					25.Quality Assurance follow-up:The Facility Services		
					Leader will report test findings		
					the Quality Assurance Commit		
					quarterly.Date of Compliance:		
					8/5/2012		

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
	155365		B. WIN			07/06/	2012
NAME OF D	DOWNED OF SUPPLIES			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				710 N E	EAST ST		
WABASH	SKILLED CARE C	CENTER		WABAS	SH, IN 46992		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG K 9999	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
Kaaaa							
	Contraction		K99	999	K9999 It is the juntent of this		07/09/2012
	State Findings				facility to ensure that a smoke		07/07/2012
					detector will be located within		
	3.1–19 ENVIRC				each resident room.What		
	PHYSICAL STAN	NDARDS			corrective actions will be		
					accomplished for those reside found to have been affected b		
	3.1–19(ff) A he	ealth facility			the deficient practice?Each	У	
	licensed under	16-28 and this			resident room will be equipped	b	
	rule must do th	ne following:			with a smoke detector. How wi		
	(1) Have an aut	tomatic sprinkler			the facility identify other reside	ents	
	system installe	d throughout the			having the potiential to be affected by the same deficeier	nt.	
	facility before J	-			practice and what corrective	11	
	(2) If an autom				action will be taken?All reside	nts	
		nstalled throughout			have the potential to be affect		
		facility before July			by the alleged deficient practic		
		it before July 1,			As of 7/9/2012 all resident roo have been equipped with a	ms	
					smoke detector. What measure	es	
		the department for			will be put into place or what		
		e installation of the			systemic changes will be mad		
	-	nkler system before			ensure that the deficient pract	ice	
	July 1, 2012.				does not occur?All smoke detectors will be tested per		
	(3) Have a batt	ery operated or			manufacturer		
		oke detector in			recommendations.How will the	е	
	each resident's	room before July 1,			corrective action be monitored		
	2012.				ensure the deficient practice d		
					not recur?All smoke detectors be tested per manufacturer	WIII	
	This State Rule	has not been met			recommendations.Quality		
	as evidenced b	y:			Assurance follow-up:The Faci	lity	
	Based on Record review and interview, the facility failed to				Services Leader will report tes		
					findings to the Quality Assurar	nce	
		detectors in each			Committee quarterly.Date of Compliance: 7/9/2012		
		n before July 1,			Compilation 1/3/2012		
	2012. This de	- · ·					
	ZOTZ. TIIIS UE	ncient practice					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	01	COMPL		
		155365	B. WIN			07/06/	2012
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
14/45 401		NEVITED.			AST ST		
WABASE	I SKILLED CARE C	ENTER		WABAS	5H, IN 46992		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)		DATE
		least 17 residents					
	in the facility.						
	Findings includ	le:					
	Based on obse	rvations with					
	Maintenance To	echnician # 8 on					
	07/06/12 from	n 2:12 p.m. to 2:17					
		ent rooms were not					
		smoke detectors.					
	-	view during the time					
	of observations						
		acknowledged all					
	the resident ro						
	provided with s	smoke detectors.					
	2.1.10/60						
	3.1-19(ff)						

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